Carver Community Organization, Inc
400 S.E. 8th Street, Evansville, IN. 47713
(Main Office) 812 423-2612 • Fax 423-6941

AFTER SCHOOL PROGRAM ENROLLMENT APPLICATION

Please check which one (1) program you are enrolling your child in

☐ **Elementary (K-5th)** • ☐ **Middle (6th – 8th)** • ☐ **High School**

Child's Name _____ Nickname _____

☐ Male ☐ Female Age _____ DOB ___/___/____ Grade _____

School Name _____

Homeroom Teacher's Name _____

FAMILY INFORMATION

Mother/Guardian's Name _____
Address & Zip Code _____
Home Phone _____ Cell Phone _____

Place of Employment _____
Address _____ Work # _____

Father/Guardian's Name _____
Address & Zip Code _____
Home Phone _____ Cell Phone _____

Place of Employment _____
Address _____ Work # _____

Who has legal custody of the above named child? _____

PROGRAM HOURS OF OPERATION:

Carver's School-Age Programs hours are as follows:
After School (School year) 2:30pm – 5:30pm K-5th 3:00 pm – 7:00 pm 6th-12th
(Summer) 1:00pm – 5:00pm (All Grades)

ALL PARTICIPANTS ARE TO BE PICKED UP NO LATER THAN 5:45pm

☐ I authorize my child to walk home from Carver Community Organization, Inc.
☐ My child is **NOT** authorized to walk home from Carver Community Organization, Inc.

Please list (3) three responsible adult persons who can be reached in case parent/guardian cannot be reached in case of an emergency.

Name_____ Relationship _____
Telephone # _____ Alternate Phone # _____

Name_____ Relationship _____
Telephone # _____ Alternate Phone # _____

Name_____ Relationship _____
Telephone # _____ Alternate Phone # _____

Signature of Parent/Guardian _____

EMERGENCY MEDICAL AUTHORIZATION

I agree, and by my signature give consent that in case of an accident or illness of a serious nature my child will be given emergency medical care. I understand that I will be contacted immediately, or as soon as possible should I be away from the phone number provided with this application.

Signature of Parent/Guardian _____

Physician's Name: _____ Office Address _____
Telephone # _____

Dentist's Name: _____ Office Address _____
Telephone # _____

Eating Habits
Does your child have any type of eating disorders? ☐ Yes ☐ No
(If yes, please explain) _____
_____
_____

AUTHORIZATION FOR PICK UP

We will not release your child to anyone without your authorization.

Name _____ Telephone # _____

Name _____ Telephone # _____

Name _____ Telephone # _____

Carver Community Organization, Inc
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Dear Parent/Guardian(s):

The United Way of Southwestern Indiana and various other funding sources, local newspapers, and other organizations occasionally request photographs of the activities provided by Carver Community Organization, Inc.

We need your permission to release any photographs of your child to any of our funding sources, organizations, and the news media.

Thank you in advance for your cooperation.

Please check one of the following statements:

☐ Yes, I give my permission for _____'s picture to be taken and released for publicity.

☐ No, I do not give my permission for _____'s picture to be taken.

Parent/Guardian's signature _____

Date: _____

E V S C

EVANSVILLE – VANDERBURGH School Corporation
Evansville, Indiana

PARENTAL PERMISSION for RELEASE INFORMATION
or REQUEST FOR REVIEW OF STUDENT INFORMATION

I, _____ hereby authorize the
(Parent/Guardian/18 year old student)

Evansville-Vanderburgh School Corporation to release the following portions of the record (*) regarding

_____
Name of student Birthday School last attended

Records Requested

1. Grades
2. Attendance
3. ISTEP
4. Behavior
5. _____

THESE RECORDS MAY NOT BE RELEASED TO ANY OTHER PARTY AND/OR AGENCY WITHOUT PRIOR APPROVAL OF THE PARENT/GUARDIAN AND/OR ELIGIBLE STUDENT, EXCEPT WHEN A WRITTEN REQUEST IS MADE BY ANOTHER EDUCATIONAL INSTITUTION OUTSIDE THE EVANSVILLE-VANDERBURGH SCHOOL CORPORTAION.

To

Carver Community Organization, Inc.
School/Agency

400 S.E. 8th Street

Evansville, Indiana 47713

The reason for this request is to track pertinent information in regards to the student's academic and behavioral progression. Thus allowing us to better serve and collaborate with the student's family, teachers, and school. This information is a requirement for students attending Carver Community Organization's after school program.

_____ _____
Authorized Signature Relationship

_____ _____
Address Telephone Number

Date _____

Computing Annual Income Worksheet

Name:			Identification No:			
ANTICIPATED ANNUAL INCOME						
	Family Member					Subtotal (add a-e)
	a.	b.	c.	d.	e.	
1. Wages/Salaries						
2. Business Income						
3. Interest/Dividends						
4. Benefits/Pension						
5. Social Security						
6. SSI						
7. SSDI						
8. Unemployment Benefits						
9. TANF						
10. Veterans Benefits						
11. Medicaid						
12. Other (please specify)						
Total of last column. This is Annual Household Income:						

Household size: _____

This household income is within the income range for HUD Income guidelines:
(circle one) 0-30% 31-50% 51-80% 81% and over

CARVER COMMUNITY ORGANIZATION, INC
400 S.E. 8TH STREET
EVANSVILLE, IN 47713

EXECUTIVE DIRECTOR: DAVID WAGNER
NEIGHBORHOOD CENTER COORDINATOR: DEIONA CLAYTON
(812) 463-6948 EXT 2207

To Whom It May Concern:

I hereby authorize and request that Carver Community Organization be given the information specified on the reverse side, which is necessary to determine childcare fees or other record keeping purposes. This is without any liability to you whatsoever; you may retain a copy of this authorization for your records.

Please complete Section _____ on the reverse side of this form and return to:

Carver Community Organization, Inc.
400 S.E. 8th Street
Evansville, IN 47713

Signed: _____

Address: _____
Street Address

_____
State City Zip Code

Social Security #: _____

Date: _____

Section A. Verification of Wages (To be completed by employer.)

Annual gross income amount: $ _____

Approximate # of hours employee will work per week: _____

Is this individual still employed?

- ☐ Yes
- ☐ No

If not, when was employment terminated? _____

On what basis is pay received? (Please check one.)

- ☐ Weekly
- ☐ Bi-Weekly
- ☐ Bi-Monthly
- ☐ Monthly

Name of employer: _____

Address of Employer: _____

Street Address City State Zip

Signature of official completing form: _____ Title: _____

Phone #: (___) _____ Date: _____

Section B: Verification of Other Income for 30 Days Prior to the Application Date (To be completed by employer.)

Type of income: _____

Total income received from _____ through _____

Gross Amount: $ _____

Signed: _____ Phone: _____

Position Title: _____ Date: _____

Section C: Verification of Training/Education Program

(To be completed by school or training facility.)

Please indicate total number of hours student is scheduled to attend class or training each week: _____

Length of Training/Education Program: _____

Hours remaining until completion: _____

Is this an accredited program?

- ☐ Yes
- ☐ No

Signature of School/Training Representative: _____

Title: _____ Phone #: _____

Date: _____

Building For the Future

This day care facility participates in the Child and Adult Care Food Program (CACFP), a Federal program that provides healthy meals and snacks to children receiving day care.

Each day more than 2.6 million children participate in CACFP at childcare homes and centers across the country. Providers are reimbursed for serving nutritious meals that meet USDA requirements. The program plays a vital role in improving the quality of day care and making it more affordable for low-income families.

Meals CACFP homes and centers follow meal requirements established by USDA.

Breakfast	Lunch or Supper	Snacks (Two of the four groups:)
Milk Fruit or Vegetable Grains or Bread	Milk Meat or meat alternate Grains or bread Two different servings of fruits or vegetables	Milk Meat or meat alternate Grains or bread Fruit or vegetable

Participating Facilities Many different homes and centers operate CACFP and share the common goal of bringing nutritious meals and snacks to participants. Participating facilities include:

- **Child Care Centers**: Licensed or approved public or private nonprofit child care Centers, Head Start programs, Outside-School-Hours programs, and some for-profit centers.
- **Family Child Care Homes**: Licensed or approved private homes.
- **At-Risk After School Meal Programs**: Centers in low-income areas provide free snacks and suppers to School-age children and youth.
- **Emergency Shelters**: Programs providing meals to homeless children.

Eligibility State agencies reimburse facilities that offer non-residential day care to the following children:

- Children age 12 and under,
- Migrant children age 15 and younger, and
- Youths through 18 in after school care programs in needy areas.

Contact Information If you have questions about CACFP, please contact one of the following:

Sponsoring Organization/Center

Carver Community Organization, Inc.
400 S.E. 8th Street
Evansville, IN 47713
Phone: (812) 423-2612
Fax: (812) 423-6941

Indiana Department of Education

CACFP Staff
School & Community Nutrition
115 West Washington Street
South Tower, Suite 600
Indianapolis IN 46204
800-537-1142 or 317-232-0850

The USDA is an equal opportunity provider and employer.

INSTRUCTIONS FOR COMPLETING THE CACFP APPLICATION FOR FREE AND REDUCED PRICE MEALS (Child Care)

Follow these instructions, if your **household gets SNAP OR TANF**:

Part 1: List all household members and birth dates for children.
Part 2: List the case number for any household member (including adults) receiving Food Stamps or TANF.
Part 3: Skip this part.
Part 4: Skip this part.
Part 5: Sign the form and enter the contact information. The last four digits of a Social Security Number are not necessary.
Part 6: Sign this part it you do not want your application information shared with Medicaid or Hoosier Healthwise.
Part 7: Answer this question if you choose.

If you are applying on behalf of a FOSTER CHILD, follow these instructions:

If all children you are applying for are foster children, or if you are only applying for benefits for the foster child:

Part 1: List all foster children. Check the box indicating that the child is a foster child.
Part 2: Skip this part.
Part 3: Skip this part.
Part 4: Skip this part.
Part 5: Sign the form and complete the contact information. A Social Security Number is not necessary.
Part 6: Sign this part it you do not want your application information shared with Medicaid or Hoosier Healthwise.
Part 7: Answer this question if you choose.

If some of the children in the household are foster children.

Part 1: List all household members. For any person, including children, with no income, you must check the "No Income Box." Check the box if the child is a foster child.
Part 2: If the household does not have a case number, skip this part.
Part 3: If any child you are applying for is homeless, migrant, or a runaway check the appropriate box and call [sponsor contact and phone number]. If not, skip this part.
Part 4: Follow these instructions to report total household income from this month or last month:

Section A – Name: List only the first and last name of **each** person living in your household with income, related or not (such as grandparents, other relatives, or friends who live with you). Include yourself and all children living with you. Attach another sheet of paper if you need to.

Section B – Gross Income and How Often it was Received: for each household member, list each type of income received for the month. You must tell us how often the money is received – weekly, every other week, twice a month or monthly.
In Box 1 - list the **gross income,** not the take-home pay. Gross income is the amount earned before taxes and other deductions. You should be able to find it on your stub or your boss can tell you.
In Box 2 - list the amount each person got from the month from welfare, child support, alimony.
In Box 3 - list retirement, Social Security, Supplemental Security Income (SSI), Veteran's benefits (VA benefits), disability benefits.
In box 4, list ALL OTHER INCOME SOURCES including Worker's Compensation, unemployment, strike benefits, regular contributions from people who do not live in your household, and any other income. For ONLY the self-employed, under *Earnings From* Work, report income after expenses. This is for your business, farm or rental property. Do not include income from SNAP, FDPIR, WIC or Federal education benefits. If you are in the Military Housing Privatization Initiative or get combat pay, do not include this housing allowance as income.

INSTRUCTIONS FOR COMPLETING THE CACFP APPLICATION FOR FREE AND REDUCED PRICE MEALS (Child Care)

Part 5: Adult household member must sign the form, complete the information, and list the last four digits of the Social Security Number or mark the box if s/he doesn't have one.
Part 6: Sign this part it you do not want your application information shared with Medicaid or Hoosier Healthwise.
Part 7: Answer this question if you choose.

ALL OTHER HOUSEHOLDS, including WIC households, follow these instructions:
Part 1: List all household members. For any person, including children, with no income, you must check the "No Income Box."
Part 2: Skip this part.
Part 3: Skip this part.
Part 4: Follow these instructions to report total household income from this month or last month:

Section A–Name: List only the first and last name of each person living in your household with income, related or not (such as grandparents, other relatives, or friends who live with you). Include yourself and all children living with you. Attach another sheet of paper if you need to.

Section B – Gross Income and How Often it was Received: for each household member, list each type of income received for the month. You must tell us how often the money is received – weekly, every other week, twice a month or monthly.
In Box 1 - list the **gross income,** not the take-home pay. Gross income is the amount earned before taxes and other deductions. You should be able to find it on your stub or your boss can tell you.
In Box 2 - list the amount each person got from the month from welfare, child support, alimony.
In Box 3 - list retirement, Social Security, Supplemental Security Income (SSI), Veteran's benefits (VA benefits), disability benefits.
In box 4, list ALL OTHER INCOME SOURCES including Worker's Compensation, unemployment, strike benefits, regular contributions from people who do not live in your household, and any other income. For ONLY the self-employed, under *Earnings From* Work, report income after expenses. This is for your business, farm or rental property. Do not include income from SNAP, FDPIR, WIC or Federal education benefits. If you are in the Military Housing Privatization Initiative or get combat pay, do not include this housing allowance as income.

Part 5: An adult household member must sign the form, complete the information, and list the last four digits of his or her Social Security Number, or mark the box if he or she doesn't have one.
Part 6: Sign this part it you do not want your application information shared with Medicaid or Hoosier Healthwise.
Part 7: Answer this question if you choose.

Privacy Act Statement: This explains how we will use the information you give us.

Non-discrimination Statement: This explains what to do if you believe you have been treated unfairly.

This institution is an equal opportunity provider.

CACFP Application for Free and Reduced Price Meals (Child Care)

Sponsor Name:	Phone Number:
Center:	FDC Provider:

Part 1. All Household Members Names of all household (First, Middle Initial, Last)	Birth Dates of Children	Check if a foster child (the legal responsibility of a welfare agency or court) * If all children listed below are foster children, skip to Part 4 to sign this form.	Check if NO income
		☐	☐
		☐	☐
		☐	☐
		☐	☐
		☐	☐
		☐	☐

Part 2. Benefits: If any member of your household received [Food Stamps] or [State TANF cash assistance], provide the name and case number for the person who receives benefits. **If no one receives these benefits, skip to Part 3.**

Name: _____ Case number: _____

Part 3. If any child you are applying for is homeless, migrant, or a runaway check the appropriate box and call [Insert center contact and phone number] Homeless ☐ Migrant ☐ Runaway ☐

Part 4. Total Household Gross Income—You must tell us how much and how often Check if **NO** income ☐

A. Name (List only household members with income)	B. Gross income and how often it was received 1. Earnings from work before deductions	2. Welfare, child support, alimony	3. Pensions, retirement, Social Security, SSI, VA benefits	4. All other income
(Example) *Jane Smith*	$200/weekly	$150/twice a month	$100/monthly	$ /
	$ /	$ /	$ /	$ /
	$ /	$ /	$ /	$ /
	$ /	$ /	$ /	$ /
	$ /	$ /	$ /	$ /
	$ /	$ /	$ /	$ /

Part 5. Signature and Last Four Digits of Social Security Number (Adult must sign)

An adult household member must sign this form. **If Part 4 is completed, the adult signing the form must also list the last four digits of his or her Social Security Number or mark the "I do not have a Social Security Number" box.** (See Privacy Act Statement on the back of this page.)

I certify that all information on this form is true and that all income is reported. I understand that the center or day care home will get Federal funds based on the information I give. I understand that CACFP officials may verify the information. I understand that if I purposely give false information, the participant receiving meals may lose the meal benefits, and I may be prosecuted.

Sign here: _____ Print name: _____

Date: _____

Address: _____ Phone Number: _____

City: _____ State: _____ Zip Code: _____

Last four digits of Social Security Number: XXX - XX - ____ ☐ I do not have a Social Security Number

_____ Initial here if you consent to allow [Provider's Name] to collect your form and provide it to the Sponsor. [Provider's Name] will not review your form.

Part 6: Other Benefits: The LAs allows us to tell Medicaid and Hoosier Healthwise that your children are eligible for free or reduced price meals. We may share your application information with Medicaid or Hoosier Healthwise unless you do not want us to. If you do not want us to share this information, please sign here:

_____ For information about Hoosier Healthwise health insurance

Signature of Parent or Guardian Call **1-800-889-9949**

CACFP Application for Free and Reduced Price Meals (Child Care)

A child enrolled in the day care facility may qualify for free or reduced price meals if the household income falls at or below the limits on this chart:

July 1, 2017 to June 30, 2018			
Household Size	Monthly Income	Household Size	Monthly Income
1	1,860	5	4,437
2	2,504	6	5,082
3	3,149	7	5,726
4	3,793	8	6,371
For each additional family member, add **$645**			

Part 7. Participant's ethnic and racial identities (optional)

Mark one ethnic identity:	Mark one or more racial identities:
☐ Hispanic or Latino	☐ Asian ☐ American Indian or Alaska Native
☐ Not Hispanic or Latino	☐ White ☐ Native Hawaiian or Other Pacific Islander
	☐ Black or African American

Privacy Act Statement: The Richard B. Russell National School Lunch Act requires the information on this application. You do not have to give the information, but if you do not, we cannot approve the participant for free or reduced price meals. You must include the last four digits of the Social Security Number of the adult household member who signs the application. The Social Security Number is not required when you apply on behalf of a foster child or you list a Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) case number for the participant or other (FDPIR) identifier or when you indicate that the adult household member signing the application does not have a Social Security Number. We will use your information to determine if the participant is eligible for free or reduced price meals, and for administration and enforcement of the program.

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

(1) mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410;
(2) fax: (202) 690-7442; or
(3) email: program.intake@usda.gov.

This institution is an equal opportunity provider.

Child Care Representative Use Only

Annual Income Conversion: Weekly X 52 – Every 2 Weeks X 26 – Twice a Month X 24 – Monthly X 12

Section A *Mark one of the boxes below to show how you are going to determine eligibility.*

☐ **Food Stamp or TANF Household**—The Food Stamp or TANF number meets the criteria for an acceptable case number. Complete Section B & C **OR**

☐ **Foster Child**—Compare the foster child's personal income to the guidelines. Complete Section B & C **OR**

☐ **Household Income**—Complete the information below and Complete Section B & C

Total Household Size: _____

Total Household Income

$_____ / _____

Example: $100/week

Compare total household income to current USDA Income Eligibility Guidelines. When the household incomes are listed for different pay periods, you must convert all income to monthly or annual income. Use the conversion listed above.

Section B

Based on the information provided, this application will be:

☐ Approved Free ☐ Approved Tier I
☐ Approved Reduced ☐ Approved Tier II
☐ Paid

Use this space for income calculation.

Section C

_____
Signature of Sponsor Representative

_____
Date of Approval

This form expires one year from the date it was approved

CHILD ENROLLMENT FORM

IDOE/CACFP
July 2017

Name of Institution: ______ Sponsor ID Number: ______
Name of Facility: ______

Child's Name: ______ **Birthdate:** ______

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Please enter the normal hours your child is in care on the specific days of care.							
Please check (√) the meals your child normally receives while in care.	Breakfast___ AM snack___ Lunch______ PM snack___ Supper_____ Night snack__	Breakfast___ AM snack___ Lunch______ PM snack___ Supper_____ Night snack__	Breakfast___ AM snack___ Lunch______ PM snack___ Supper_____ Night snack__	Breakfast___ AM snack___ Lunch______ PM snack___ Supper_____ Night snack__	Breakfast___ AM snack___ Lunch______ PM snack___ Supper_____ Night snack__	Breakfast___ AM snack___ Lunch______ PM snack___ Supper_____ Night snack__	Breakfast___ AM snack___ Lunch______ PM snack___ Supper_____ Night snack__

If your school-age child will be in attendance outside of the regular hours indicated above (snow days, school breaks, etc.) Please check (√) here ______

FOR INFANTS ONLY: All facilities must offer infant formula and meals/snacks to infants in care during meal service times

Infant Formula
This facility will provide the following iron-fortified infant formula: ______
Check here to accept: ☐ Check here to decline: ☐ Provide name of parent-provided formula: ______
Infant Meals and Snacks
Check here to accept: ☐ Check here to decline: ☐

This information is required by CACFP federal regulations at §226.15 (e)(2) and (3) for each enrolled participant, and must be updated annually.

Printed name of parent/guardian: ______ Phone Number: ______

Signature of parent/guardian: ______ Date: ______